MOTION FILED

OCT 2 9 1993

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE*

*THERESA L. SOROTA
LYNNE E. FRITTER
B. MICHAEL HERMAN
Health Insurance Association of America
1025 Connecticut Ave., N.W.
Washington, D.C. 20036
(202) 223-7822

ANNE MARIE WALSH
American Association of Preferred Provider Associations
1101 Connecticut Ave., N.W.
Washington, D.C. 20036
(202) 429-5133

KELLI D. BACK
American Managed Care and Review Association
1227 25th Street, N.W.
Suite 610
Washington, D.C. 20037
(202) 728-0506

Attorneys for Amici

**Counsel of Record*

BEST AVAILABLE COPY

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

No. 93-510

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,

Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

---

MOTION OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN ASSOCIATION OF PREFERRED PROVIDER ORGANIZATIONS, AND AMERICAN MANAGED CARE AND REVIEW ASSOCIATION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF THE PETITION

Pursuant to Rule 37.2 of the Rules of this Court, *amici*, the Health Insurance Association of America ("HIAA"), Association of Preferred Provider Organizations ("AAPPO"), and American Managed Care and Review Association ("AMCRA"), hereby move for leave to file the attached brief *amicus curiae*. Petitioner has granted but respondent has refused to

grant consent for *amici* to file a brief *amicus curiae* in support of the petition.

Amici bring a unique and broad perspective to the issue brought before this Court. ERISA preemption and its relation to the Virginia "any willing provider" statute affects most of our collective membership, including large and small insurers and companies operating preferred provider organizations (PPOs) which are neither health care providers nor health insurance carriers.

Amici can bring to this Court's attention relevant matters that could not be brought fully to the Court's attention by petitioner and that respondent is unlikely to bring to the Court's attention. In particular, *amici* point out how the holding of the Fourth Circuit Court of Appeals will, if allowed to stand, inhibit the ability of employee welfare benefit plans to contain and control health care costs through the use of managed care networks.

Amici therefore respectfully request leave to file the attached brief *amicus curiae*.

Respectfully submitted,

/s/ Theresa L. Sorota

*THERESA L. SOROTA
LYNNE E. FRITTER
B. MICHAEL HERMAN
Health Insurance Association of America
1025 Connecticut Ave., N.W.
Washington, D.C. 20036
(202) 223-7822

ANNE MARIE WALSH
American Association of Preferred Provider Associations
1101 Connecticut Ave., N.W.
Washington, D.C. 20036
(202) 429-5133

KELLI D. BACK
American Managed Care and Review Association
1227 25th Street, N.W.
Suite 610
Washington, D.C. 20037
(202) 728-0506

Attorneys for Amici

**Counsel of Record*

October 29, 1993

TABLE OF CONTENTS

	Page
TABLE OF CONTENTS	i
TABLE OF AUTHORITIES	ii
INTERESTS OF THE AMICI	1
REASONS FOR GRANTING THE WRIT	5
A. The Fourth Circuit's Decision Will Adversely Affect Amici's Members' Ability to Contain Escalating Health Care Costs	6
B. The Fourth Circuit Failed to Apply the Appropriate Precedent Articulated By This Court in Royal Drug That the Selection of Network Providers Is Not the "Business of Insurance"	10
C. Proliferation of "Any Willing Provider" Legislation Will Erode the Ability of Insurers and Other Third Party Payors to Create Effective Managed Care Networks	14
CONCLUSION	16

TABLE OF AUTHORITIES

Cases: Page

Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979), *cert. denied*, 469 U.S. 1160 (1985) 6,11,12,13

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) 5,11,13

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) 15

Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983) 11

Stuart Circle Hosp. Corp. v. Aetna Health Management; Aetna Life Ins. Co., 995 F.2d 500 (1993) 3,12

Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982) 11

Statutes:

Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 *et seq.* ..... *passim*

29 U.S.C. § 1144(b) 10

McCarran-Ferguson Act, 15 U.S.C. §1011 *et seq.* . 11

Ala. Code § 27-45-3 (1988) 14

Ark. Stat. Ann. § 23-79-143 (1991) 14

Cal. Ins. Code §10133 *et seq.* 9

Conn. Gen. Stat. § 38A-471 (1981) 14

Fla. Stat. § 408.706(10) (1993) 14

Ga. Code Ann. § 33-30-4.3 (1991) 14

Idaho Code § 41-1844 (1991) 14

215 Ill. Comp. Stat. Ann. 5/370h (1993) 14

Ind. Code Ann. § 27-8-11-3 (Burns 1992) 14

La. Rev. Stat. Ann. 22:1214(15) (West 1992) 14

Table of Authorities Continued

	Page
N.C. Gen. Stat. § 58-51-58 (1993)	14
N.D. Cent. Code § 26.1-36-12.2 (1989)	14
S.D. Codified Laws Ann. § 58-18-37 (1990)	14
Utah Code Ann. § 31A-22-617 (1991)	14
Va. Code § 38.2-3407 (1993)	3,5
1993 Wash. Laws Chapter 492	14
W.Va. Code § 33-25A-31 (1991)	14
Wis. Stat. Ann. § 628.36 (1991 & Supp. 1992)	14
Wyo. Stat. § 26-22-503 (1977)	14

Other Authorities:

Directory of Operational PPOs, SMG Marketing Group Inc. (9th ed. 1993)	10
Glenn A. Melnick, et al. The Growth and Effects of Hospital Selective Contracting, Health Care Manage Rev. (1989)	9
Health Care Benefits Survey 1992, A. Foster Higgins & Co., Inc. (1992)	10
Insurer-Sponsored Managed Health Care: 1990, Health Insurance Association of America (1991)	2
Report to Health Insurance Association of America: Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices, 14-26 (Wyatt Co. 1991)	7,8

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

No. 93-510

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,

Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

---

BRIEF AMICUS CURIAE FOR THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN ASSOCIATION OF PREFERRED PROVIDER ORGANIZATIONS, AND AMERICAN MANAGED CARE AND REVIEW ASSOCIATION IN SUPPORT OF THE PETITION

INTERESTS OF THE AMICI

The Health Insurance Association of America ("HIAA"), the American Association of Preferred Provider Organizations ("AAPPO"), and the American Managed Care and Review Association

("AMCRA") submit this *amicus curiae* brief in support of petitioners.[1]

HIAA is a non-profit national trade organization representing over 250 commercial health insurers that provide health care coverage to over 65 million Americans. Many of HIAA's member companies either own, operate, or lease health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), and other entities whose primary purpose is to provide health care services through a managed care system. Approximately 50 percent of all HIAA members offer at least one network-based managed care product. Additionally, more than two-thirds of the total enrollment in commercial insurers' managed care plans are in PPOs. *Insurer-Sponsored Managed Health Care: 1990*, Health Insurance Association of America (1991). Other member insurers, primarily mid-sized carriers, lease PPO networks from other insurers or enter into joint venture agreements with independent PPOs.

AAPPO is a non-profit national trade association representing PPOs, exclusive provider organizations (EPOs), and point of service (POS) plans, and their partners in managed health care. The AAPPO's 1,300 individual members represent 274 PPOs (more PPOs than all other trade associations combined), 53 insurers and more than 300 other organizations actively involved in managed care. The AAPPO represents the fastest growing health care delivery model, and its membership comprises a significant portion of both the delivery systems and recipients of health care in

[1] This brief is being filed with the consent of petitioners and by *amici's* Motion for Leave to File as *amicus curiae*.

the United States. The organization's activities include public and industry education, research, development of industry standards, and advocacy.

AMCRA is a national trade association representing over 500 managed care organizations providing health care to more than 75 million Americans. AMCRA represents the full spectrum of managed care organizations, including HMOs, independent practice associations ("IPAs"), and PPOs. These organizations provide Americans with a choice of health care plans that emphasize the appropriate use of health care facilities and services, resulting in the highest quality of health care at an affordable price.

The ability of the members of HIAA, AAPPO, and AMCRA [hereinafter *amici*] to offer cost efficient, high quality preferred provider networks through employee welfare benefit plans is jeopardized by the decision of the Fourth Circuit, which held that Virginia's "any willing provider" statute, Virginia Code § 38.2-3407, is saved from ERISA preemption as a law that regulates the "business of insurance." *Stuart Circle Hosp. Corp. v. Aetna Health Management; Aetna Life Ins. Co.*, 995 F.2d 500 (4th Cir. 1993). That statute requires that PPO networks accept any provider of health care services willing to meet the network's established criteria. Such a requirement strikes at the heart of the principles of managed care.

PPOs, HMOs, and other variations of managed care organizations are formed in order to deliver quality health care to consumers at a reduced cost. Administrators of these alternative delivery systems, which in many cases are not insurance companies, use selective contracting to negotiate prices with a limited number of providers. These "preferred" providers

typically deliver health care services to employee benefit plan participants at a substantially lower rate than non-network providers in exchange for increased patient volume.

Increased patient volume makes it possible for the provider to benefit by obtaining a larger share of the market. The promise of increased market share allows providers to predict the amount of business they will have and improves economies of scale, both of which maximize efficiency. "Any willing provider" statutes increase the number of health care providers in a network, thereby reducing each provider's total patient volume. This, in turn, reduces incentives for providers to accept reduced fees or to cooperate with utilization management mechanisms. Utilization management is the most significant method by which PPOs, HMOs and other managed care entities control health care costs and assess quality of care. Utilization management and the information derived from utilization management allow a PPO to credential and recredential providers, monitor overutilization and underutilization of health care services, and monitor and assess the quality of care provided in the network.

The limited number of participating providers in a PPO or other network setting helps contain health care costs, and plan participants realize cost savings through the use of the network providers. For instance, plan participants enrolled in a PPO plan may use the preferred (or network) providers or go outside the network to other physicians and hospitals for care. However, there are strong financial incentives designed to encourage patients to use the network providers. For example, the health care that participants

receive from preferred providers is often reimbursed at 90 to 100 percent of reasonable and customary charges. Health care obtained outside the network may be reimbursed at 80 percent or less, resulting in individuals paying more out of their own pockets.

Enforcement of Virginia's "any willing provider" statute would effectively eliminate the ability of *amici's* members to control health care costs by selectively contracting with efficient, yet highly skilled providers.

REASONS FOR GRANTING THE WRIT

The major question that petitioners have presented before this Court is whether Virginia's "any willing provider" statute, Virginia Code § 38.2-3401, regulates the "business of insurance" and therefore survives ERISA preemption. The Fourth Circuit held that the "any willing provider" statute was not preempted because it does regulate the "business of insurance." This holding effectively eliminates the ability of managed care organizations to deliver quality health care at a lower price. If provider networks become unlimited, the cost of doing business for managed care organizations will increase since it will either be impossible or considerably more expensive to impose appropriate cost controls. In addition, the likelihood of increased patient volume for individual health care providers will no longer exist. Thus, providers will no longer have a financial incentive to join PPOs at reduced fees.

In reaching its decision that the "any willing provider" statute regulates the "business of insurance," the Fourth Circuit improperly relied on *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985),

concluding that "any willing provider" laws regulate the "business of insurance." The Fourth Circuit should instead have applied the standard articulated in *Group Life & Health Ins. Co. v. Royal Drug Co., Inc.*, 440 U.S. 205 (1979), *cert. denied*, 469 U.S. 1160 (1985).

The Fourth Circuit's misapplication of the *Metropolitan Life* analysis is detrimental to *amici's* members, and accordingly, review by this Court is necessary.

A. The Fourth Circuit's decision will adversely affect *amici's* members' ability to contain escalating health care costs.

"Any willing provider" statutes, such as the Virginia statute at issue here, mandate that managed care organizations include in their networks any provider willing to meet the terms and conditions specified by the organization. These laws inhibit the effectiveness of alternate delivery systems, such as PPOs, by causing the network to become too large and costly to effectively administer. The inflated network will incur more costs and supply fewer patients to each participating health care provider; thus, diminishing or eliminating the system's overall cost savings.

One of the adverse consequences of "any willing provider" laws is the administrative difficulty of managing the larger networks that result. Increasing the number of provider applications per network requires significant staff time to process and properly verify the credentials of new applicants. New providers must be trained in network procedures. In addition, larger numbers of providers require additional monitoring by the PPO. A 1991 study by the Wyatt Company compared a simulated model of a larger network with

a baseline network. The baseline network was composed of approximately 25.5 percent of the individual health care providers and 44 percent of the hospitals in the network service area. The study concluded that if the number of network providers were increased to 40 percent of the available providers and 60 percent of the hospitals, there would be an 80.1 percent increase in the amount of administrative costs over the baseline network's administrative costs. *Report to Health Insurance Association of America: Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices*, 14-26 (Wyatt Co. 1991) [hereinafter Wyatt Study].

Another detrimental aspect of "any willing provider" laws is the potential decrease in provider claims savings. By expanding the percentage of providers in the baseline model PPO, for example, the Wyatt Study found that providers are less likely to grant as big a discount as expected because each provider will have fewer patients directed his or her way. The provider will either deliver more services or give smaller discounts in order to maintain his or her current level of income (or, in the case of hospitals, their operating margins). The Wyatt Study concludes that the possible outcome of an "any willing provider" statute could be an 8.8 percent loss in claims savings as compared with the typical PPO. Wyatt Study, *supra*, at 20.

The conclusions of the Wyatt Study demonstrate that there is a point at which a PPO will be unable to demonstrate any value to the community if it is forced to accept more than a limited percentage of available providers. In fact, 20 percent or more of the hospitals and 40 percent or more of individual

providers will need to be excluded from the network in order to serve the community as a cost effective deliverer of health care services. *Id.* at 23.

It can be inferred from the Wyatt Study that selective contracting by a PPO or other managed care organization gives health care providers an incentive to join a managed care network. In the absence of "any willing provider" legislation, network providers will experience lower administrative costs and higher patient volumes, thereby fostering both competition and cost savings. Should Virginia's "any willing provider" statute survive preemption by ERISA, providers will no longer have incentives to become more efficient and more competitive in the services they offer. There will be too many health care providers in each network, resulting in too few patients per provider and the inability of providers to control costs through economies of scale.

The higher administrative costs of dealing with larger networks mandated by Virginia's "any willing provider" statute is likely to limit the availability of PPOs in the Commonwealth. Thus, a direct consequence of the Virginia law would be to limit consumers' ability to select alternative delivery systems for health care services. Indeed, the Federal Trade Commission ("FTC") has, on many occasions, concluded that "any willing provider" legislation inhibits competition among providers by limiting providers' incentive to compete in developing attractive or innovative proposals. *See, e.g.*, Letter from Thomas B. Carter, Director of the FTC, to John Smithee, Chairman of the Texas House Insurance Committee (May 18, 1993). The FTC has also issued opinions concerning the anti-competitive nature of "any willing prov-

ider" laws to officials in six other states: Massachusetts, Montana, New Hampshire, New Jersey, Pennsylvania, and South Carolina.[2]

Moreover, the use of preferred provider networks results in health care cost savings. For example, California was the first state to enact a selective contracting law enabling the formation of PPOs. Cal. Ins. Code § 10133 *et seq.* California leads the nation in the adoption of provider networks; its biggest success involves the use of hospital selective contracting. In fact, California hospitals have experienced a marked decrease in the rate at which their expenses have increased since the enabling legislation was passed. *See* Melnick, Zwanziger, and Verity-Guerra, *The Growth and Effects of Hospital Selective Contracting,* Health Care Manage Rev. (1989). Indeed, there has been phenomenal growth of PPOs throughout the country during the last decade. According to SMG Marketing Group, there are now 1036 PPOs operating or organized nationally, up from 978 in 1991. During

---

[2] Other opinion letters include: Letter from Mary Lou Steptoe, Acting Director of the FTC, to William F. Cass, Vice-Chairman of the Massachusetts House Health Care Committee (June 15, 1993); Letter from Michael O. Wise, Acting Director of the FTC, to Joseph P. Mazurek, Montana Attorney General (February 4, 1993); Letter from Michael O. Wise, Acting Director of the FTC, to Paul J. Alfano, New Hampshire Senate Legal Counsel (March 17, 1992); Letter from Michael O. Wise, Acting Director of the FTC, to E. Scott Garrett, Chairman of the New Jersey Assembly Insurance Committee (March 29, 1993); Letter from Michael O. Wise, Acting Director of the FTC, to Roger A. Madigan, Pennsylvania State Senator (April 19, 1993); and Letter from Michael O. Wise, Acting Director of the FTC, to Thomas C. Alexander, Chairman of the South Carolina House Labor, Commerce and Industry Committee (May 10, 1993).

the same time period, the number of employees eligible to enroll in PPOs increased more than 50 percent, to almost 58 million lives. Since 1984, the growth in the number of PPOs has averaged 40 percent annually. *Directory of Operational PPOs*, SMG Marketing Group Inc. (9th ed. 1993).

Increasingly, employers are offering PPO plans to their employees. A recent survey conducted by Foster Higgins found that in 1992, 39 percent of employers offered a PPO program, up from 31 percent in 1991, even though this type of managed care has been generally available only since about 1983. *Health Care Benefits Survey 1992*, A. Foster Higgins & Co., Inc. (1992).

The consequences of allowing the decision of the Fourth Circuit to stand would be increased health care costs to Virginia consumers. This Court should not allow states to erect roadblocks to attempts by responsible ERISA plan sponsors to contain health care costs.

B. The Fourth Circuit failed to apply the appropriate precedent articulated by this Court in *Royal Drug* that the selection of network providers is not the "business of insurance."

Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, explicitly provides that, subject to certain exceptions, ERISA preempts all state laws that relate to employee welfare benefit plans. One of the exceptions embodied in ERISA is the insurance savings clause which saves from preemption any state law regulating insurance. 29 U.S.C. § 1144(b). This Court has adopted a two-step inquiry to determine whether

a law regulates insurance within the meaning of the savings clause. First, a court must make a "commonsense" determination as to whether the law regulates the "business of insurance." *Metropolitan Life*, 471 U.S. at 739 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983)). Second, the court must consider the three criteria which this Court has established to determine whether the "business of insurance" is exempt from federal antitrust regulation under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.; Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982).

The three criteria set forth in *Pireno* are: (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the laws regulate any practice that is an integral part of the policy relationship between the insurer and the insured; and (3) whether the laws are limited to entities within the insurance industry. *Union Labor Life*, 458 U.S. at 129.

In *Royal Drug*, a Blue Shield plan entered into a contract with pharmacists, whereby the pharmacists were to provide prescription drugs to the insurer's policyholders for a $2 charge, and the insurer would reimburse the pharmacists at cost. *Royal Drug*, 440 U.S. at 209. Applying the three *Pireno* criteria, this Court held that these arrangements did not involve the spreading or transfer of risk. The court reasoned that the risk involved was the insurer's obligation to reimburse drug costs to its insureds. The insurer had already assumed that risk in its insurance contracts. The arrangement with the pharmacists did not transfer or spread that risk but merely affected the insurer's cost of satisfying its obligations on a risk it

had already assumed. *Id.* at 213. This court, therefore, held that the arrangements were not the "business of insurance." *Id.* at 214.

The same reasoning applies here. The petitioner's PPO arrangements are contracts between Aetna and the health care professionals providing the services. They do not involve the underwriting of the insured's risk; all the risks assumed in the insurance policies are covered. The PPO arrangement merely establishes a network of providers which the insured may select when seeking treatment. As this court held in *Royal Drug*, contracts between a provider and an insurer or other entity do not constitute the "business of insurance" but rather the "business of insurance companies."[3] *Id.* at 217.

The Fourth Circuit distinguished the nature of the network in this case from that in *Royal Drug*, indicating that the provider network in *Royal Drug* was not a restricted network. *Stuart Circle*, 995 F.2d at 504. As pointed out in Aetna's petition, the very fact that pharmacies were unwilling to meet the terms of the Blue Shield contract made the network a restricted one. Brief for Petitioner at 20. Moreover, this Court made clear in *Royal Drug* that the open access of pharmacies to the pharmacy agreements was irrelevant to its decision. The result would be the same, the Court explained, if "an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under

---

[3] However, it is important to note that many PPOs are established and operated by entities that are not insurance companies; and therefore, such provider contracts would not even constitute the "business of insurance companies."

their policies only from stores operated by this chain." *Royal Drug*, 440 U.S. at 215. Such an arrangement, this Court concluded, is not the "business of insurance."[4] *Id.*

When the Fourth Circuit disregarded the holding in *Royal Drug*, it purported to apply the "common sense" approach to determine whether a law regulates the "business of insurance." The common sense approach requires the Court to ask whether the statute in question addresses matters typically within the purview of state insurance regulations, such as the solvency of an insurance company, the sale and advertising of insurance, and the content of the insurance policies. *Metropolitan Life*, 471 U.S. at 742. *Metropolitan Life* involved a Massachusetts mandated benefit law which required insurers to provide coverage for the treatment of mental illness. This Court held that the mandate regulated the "business of insurance" under ERISA because the law affected how and to what extent treatment was to be covered under an insurance policy. *Id.* The Virginia statute at issue in this case is distinguishable from the mental illness mandate in Metropolitan Life. Unlike the Massachusetts statute at issue there, the Virginia statute does not dictate coverages that insurers must include in their insurance or health care contracts. In fact, it involves a completely separate document from the insurance or health care contract and does not change the obligation of the insurer or managed care organization to provide benefits to its insureds or subscribers.

---

[4] This issue is more fully discussed in Petitioner's Petition for Writ of Certiorari at page 21.

C. Proliferation of "any willing provider" legislation will erode the ability of insurers and other third party payors to create effective managed care networks.

Many states have passed anti-managed care legislation. For example, eight states have enacted "any willing provider" legislation which is substantially similar to the Virginia law.[5] In addition, nine states have enacted "any willing pharmacy" legislation, requiring pharmacy networks to accept any pharmacist willing to meet the terms and conditions of the network contract.[6] This proliferation of "any willing provider" legislation inhibits insurers and other third-party payors from developing effective managed care systems. Moreover, the increasing number of "any willing provider" laws enacted by the states compels companies which do business in multiple jurisdictions to comply with the requirements of varying laws, resulting in exactly the type of patchwork administra-

---

[5] The eight states and the "any willing provider"statutes they have enacted are: Georgia, Ga. Code Ann. § 33-30-4.3 (1991); Illinois, 215 Ill. Comp. Stat. Ann. 5/370h (1993); Indiana, Ind. Code Ann. § 27-8-11-3 (Burns 1992); South Dakota, S.D. Codified Laws Ann. § 58-18-37 (1990); Utah, Utah Code Ann. § 31A-22-617 (1991); Washington, 1993 Wash. Laws Chapter 492; West Virginia, W.Va. Code § 33-25A-31 (1991); and Wyoming, Wyo. Stat. § 26-22-503 (1977).

[6] The nine states and the "any willing pharmacy" statutes they have enacted are: Alabama, Ala. Code § 27-45-3 (1988); Arkansas, Ark. Stat. Ann. § 23-79-143 (1991); Connecticut, Conn. Gen. Stat. § 38A-471 (1981); Florida, Fla. Stat. § 408.706(10) (1993); Idaho, Idaho Code § 41-1844 (1991); Louisiana, La. Rev. Stat. Ann. 22:1214(15) (West 1992); North Carolina, N.C. Gen. Stat. § 58-51-58 (1993); North Dakota, N.D. Cent. Code § 26.1-36-12.2 (1989); and Wisconsin, Wis. Stat. Ann. § 628.36 (1991 & Supp. 1992).

tive scheme which Congress intended to avoid in enacting ERISA. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Finally, it should be noted that in enacting these "any willing provider" laws, states are attempting to regulate indirectly that which they clearly cannot regulate directly—employee welfare benefit plans.

CONCLUSION

For the foregoing reasons and for the additional reasons advanced in the Petition, the Court should grant the Petition for Writ of Certiorari and set the case for plenary review.

Respectfully submitted,

*THERESA L. SOROTA
LYNNE E. FRITTER
B. MICHAEL HERMAN
Health Insurance Association of America
1025 Connecticut Ave., N.W.
Washington, D.C. 20036
(202) 223-7822

ANNE MARIE WALSH
American Association of Preferred Provider Associations
1101 Connecticut Ave., N.W.
Washington, D.C. 20036
(202) 429-5133

KELLI D. BACK
American Managed Care and Review Association
1227 25th Street, N.W.
Suite 610
Washington, D.C. 20037
(202) 728-0506

Attorneys for Amici

**Counsel of Record*

October 29, 1993